Benefit Enrollment and Life Event Change Form – SAG's

A

☐ New Enrollment (check one)	☐ Employee Termination	☐ Adding Dependent (check one)	☐ Removing Dependent (check one)	Employer Name and Address: **State of New Hampshire 28 School St, Concord, NH 03301**	
☐ New Hire ☐ Rehire < 1 yr or ☐ Rehire > 1 yr ☐ RIF or Recall Placement ☐ PT/FT not benefit eligible to PT/FT benefit eligible ☐ Loss of Other Coverage ☐ Return from LOA which resulted in loss of benefits	Last Day Worked: ____/____/_____ ☐ Please check here if retiring as benefits eligible	☐ Marriage ☐ Birth ☐ Legal Guardianship ☐ Court Order ☐ Adoption ☐ Loss of Other Coverage	☐ Divorce/Legal Separation ☐ Death ☐ Access to Other Coverage ☐ Court Order ☐ Age Out – Turning 26	Employee Social Security #: NH FIRST Employee ID #:	Department: ☐ BFA S037 ☐ NHRS 5900 ☐ CDFA S038 ☐ Pease S013 ☐ DOT S096** ☐ Safety S023** ☐ LCHIP S401 ☐ SEA S015 ☐ Legislators S004 ***(Survivors)*

B

Employee Name (PLEASE PRINT): *(First Name Middle Initial Last Name)*	Employee Date of Birth: *(MM/DD/YYYY)* _____/_____/_____	Work Phone: Home Phone:
Mailing Address *(Street)* *(City)* *(State)* *(Zip Code)*		

C

First Name Middle Initial Last Name	Add, Waive or Remove	Date of Birth	Gender	Coverage Selection *(Choose one for Dental and one for Medical)*	Documentation Requirements
Employee **SAME AS ABOVE**	☐ **Add** (specify under Coverage Selection) ☐ **Waive or Remove** (specify under Coverage Selection)	**SAME AS ABOVE**	☐ M ☐ F	☐Enroll in Dental or ☐Waive/End Dental Enroll in Medical: ☐HMO or ☐POS or ☐Waive/End Medical Coverage	
Spouse/Same Gender Spouse **Relationship** ☐ Spouse ☐ Same Gender Spouse Name: _____ Spouse's SSN: _____ - _____ - _____	☐ Add ☐ Waive or Remove	Date of Birth ___/____/_____	☐ M ☐ F	☐Enroll in Dental or ☐Waive/End Dental ☐ Enroll in Medical or ☐ Waive/End Medical	Please attach supporting documentation based on event type. **Adding** - marriage certificate, proof of loss of coverage w/marriage cert, etc. **Removing** - divorce decree, death certificate, proof of other insurance, etc.
Additional dependent children should be listed on a second form. Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Waive or Remove	Date of Birth ___/____/_____	☐ M ☐ F	☐Enroll in Dental or ☐Waive/End Dental ☐ Enroll in Medical or ☐ Waive/End Medical	Please attach supporting documentation based on event type. **Adding** - birth cert, adoption paperwork w/birth cert, court order w/birth cert, proof of loss of coverage w/birth cert, etc. **Removing** – proof of other insurance, death certificate, court order, etc.
Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Waive or Remove	Date of Birth ___/____/_____	☐ M ☐ F	☐Enroll in Dental or ☐Waive/End Dental ☐ Enroll in Medical or ☐ Waive/End Medical	

D

The information provided above is true and correct to the best of my knowledge. I also understand that the dependent coverage will not be effective until I provide appropriate documentation to my agency Human Resource office.

Employee Signature:_____ **Date:** _____/_____/_____

** **Please make a copy of this form for your personal records****

For Agency Benefit Representative Use Only	**Agency Name**	**Agency Benefit Representative Name**	**Contact #**	**Date Sent to DOP**	**Event Date (Date of Hire or Life Event)**	**Coverage Start or End Date**
Payroll #: _ _ _ _						

FOR DOP USE ONLY: Date NH FIRST Updated: _____ Initials: _____

Revised 8/14/14 - TH